STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Program	Limitations

2. Contact lens evaluation and fitting;

3. Refractions for the purpose of prescribing eyeglasses;

4. Consultations provided by physicians specializing in radiology or pathology;

5. Lipectomy and panniculectomy;

6. All evaluations, procedures and treatment related in any way to sex reassignment;

7. Medical Assistance prescriptions and injections for female hormones for biologic males;

8. Medical Assistance prescriptions and injections for male hormones for biologic females;

9. Transplantations of vital organs.

10. Surgical procedures for the treatment of obesity.

B. Services which have been determined by Medicare to be ineffective, unsafe, or without proven clinical value are generally presumed to be not medically necessary, but will be preauthorized if the provider can satisfactorily document medical necessity in a particular case. These services are found in the Medicare Carriers Manual, Part 3, Claims Process, Chapter II, Coverage Issues Appendix.

C. Physicians dispensing eyeglasses shall comply with the requirements of COMAR 10.09.14 and COMAR 10.09.23.

D. The Department will preauthorize services when the provider submits to the Department adequate documentation demonstrating that the service to be preauthorized is necessary and appropriate. "Necessary" means directly related to diagnostic, preventive, curative, palliative or rehabilitative treatment; "appropriate" means an effective service that can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of any alternative services which could be used for the same purpose.

E. Services rendered to a hospital inpatient prior to the day immediately preceding surgery must be preauthorized.

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Program	Limitations
	F. Certain surgical procedures identified under "Inpatient Services" (Attachment 3.1A page 12B number 11) must be preauthorized when performed on a hospital inpatient basis unless: 1. The patient is already a hospital inpatient for a medically necessary condition unrelated to the surgical procedure requiring preauthorization, or 2. An unrelated procedure which requires hospitalization is being performed simultaneously. G. Preauthorization normally required by the Program is waived when the service is covered and approved by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing.

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Program	Limitations
6. Medical care and any other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law. a. Podiatrists' Services	A. The following are not covered: 1. Physical therapy; 2. Orthotics and inlays of any type, and related services; 3. Disposable medical supplies; 4. Administration of anesthesia as a separate charge; 5. Corrective shoes; 6. Braces; 7. Personal hygiene care; 8. Routine care, except visits for continued or chronic podiatric care for recipients who are diabetic or who have a vascular disease affecting the lower extremities; 9. Non-surgical hospital visits; 10. Laboratory or x-ray services not performed by the provider or under the direct supervision of the provider; 11. Podiatric inpatient hospital services rendered during an admission denied by the utilization control agent or during a period that is in excess of the length of stay authorized by the utilization control agent. B. Continued podiatric care is limited to a maximum of five visits or 90 days care, whichever occurs first. Preauthorization is required for more than five visits or care beyond 90 days. C. Chronic podiatric care is limited to a maximum of one visit every 6 weeks.

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GRAM	LIMITATIONS
a. Podiatrists' Services	D. Billing time limitations: 1. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. 2. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (a) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (b) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. 3. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service. 4. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later. 5. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

See Page 9-2

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PROGRAM	LIMITATIONS
Services that require Preauthorization	A. Preauthorization is required for the following: 1. Continued podiatric in excess of either five visits or 90 days care;

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Program	Limitations
6.a. Podiatrists' Services (continued)	2. Any procedure not included in a current fee schedule. 3. Certain surgical procedures identified under "Inpatient Services" (Attachment 3.1A page 12B number 11) which may be performed by a Podiatrist must be preauthorized when performed on a hosptial inpatient basis unless: a. The patient is already a hospital inpatient for a medically necessary condition unrelat to the surgical procedure requiring pre-authorization; or b. An unrelated procedure which requires hospitalization is being performed simultaneously. B. Preauthorization is issued when: 1. Program procedures are met; 2. The provider submits to the Department adequate documentation demonstrating that the service to be preauthorized is necessary and appropriate ("necessary" means directly related to diagnostic, preventive, curative, palliative, or rehabilitative treatment; "appropriate" means an effective service that can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of any services which could be used to the same purpose). C. Preauthorization is valid only for services rendered or initiated within 60 days of the date issued. D. Preauthorization normally required by the Program is waived when the service is covered and approved by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing. Non-Medicare claims require preauthorization according to §§A-C.

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PROGRAM	LIMITATIONS
6. b. Optometrists Services	A. Eye examinations: A maximum of one every two years, unless the time limitations are waived by the Department, based on medical necessity. B. The following are not covered: 1. Repairs to eyeglasses; 2. Combination or metal frames except when required for proper fit; 3. Cost of travel by the provider; 4. A general screening of a Medical Assistance population; 5. Visual training sessions which do not include orthoptic treatment; 6. Routine adjustment; 7. Billing time limitations: a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.

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PROGRAM (Continued)	LIMITATIONS
5. b. Optometrists Services See Page 4-2	d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later. e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 month of the date on which eligibility was determined. C. See also limitations under 12D.
Services that require Preauthorization	A. The following services require preauthorization: 1. All eye examinations; 2. Eyeglasses; 3. Contact lenses; 4. Sub-normal vision aid examination and fitting; 5. Orthoptic treatment sessions; 6. Plastic lenses costing more than equivalent glass lenses unless there are six or more diopters of spherical correction or three or more diopters of astigmatic correction; 7. Progress evaluations; 8. Absorbtive lenses, except cataract;

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Program	Limitations
6.b. Optometrists' Services (continued)	9. Ophthalmic lenses or optical aids when the diopter correction is less than: a. -0.50D. sphere for myopia in the weakest meridian; b. +0.75D. sphere for hyperopia in the weakest meridian; c. +0.75 additional for presbyopia; d. ±0.75D. cylinder for astigmatism; e. A change in axis of 5° for cylinders of 1.00 diopter or more; f. A total of 4Δ (prism diopters) lateral or a total of 1Δ vertical. B. Preauthorization is issued when: 1. Program procedures are met; 2. Program limitations are met; 3. The provider submits to the Department adequate documentation demonstrating that the service to be preauthorized is necessary and appropriate ("necessary" means directly related to diagnostic, preventative, curative, palliative, or rehabilitative treatment; "appropriate" means an effective service that can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of any services which could be used to the same purpose). C. Preauthorization is valid only for services rendered or initiated within 60 days of the date issued. D. Preauthorization normally required by the Program is waived when the service is covered and approved by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing. Non-Medicare claims require preauthorization according to ~~88~~A-C.

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PROGRAM	LIMITATIONS
(Continued) Services that require preauthorization	1. Services provided by out-of-state agencies must be, preauthorized or reimbursed on individual determination. 2. Services that exceed 8 visits per recipient per calendar month, must be preauthorized.
7.b. Home health aid services provided by a home health agency. See Page 9-2	1. Home health aide services must come under the direct supervision of a nurse. 2. Billing time limitations: a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.

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